Medical Consultant Report and Summary

Case No:
Date: January 25, 2006

Physician:
Medical Consultant:

1. **Detailed (Chronological) Analysis:** On March 2nd, 2002, a 34 day old infant, with a history of significant prematurity , chronic bloody stools and abdominal distension, presented to Emergency at 2 am with symptoms of frequent vomiting since approximately 10:30 pm (the night prior). The infant was attended by He obtained a history from the patient's mother, performed a physical exam, ordered blood work (a blood count and chemistry profile), ordered an x-ray of the abdomen and chest, and instituted fluid therapy intravenously.

exam was unremarkable. Of particular note, the abdomen was soft and normal bowel sounds were present. Emergent labs revealed a normal white count and chemistries. Skin color and vascular perfusion were normal, as well as the infant's neonatal reflexes (including sucking.)

The x-ray of the abdomen was interpreted to be non-specific in gas pattern by both Dr. and the attending radiologist.

Dr. discussed this case with the patient's attending at 3am, merely 40 minutes after his initial evaluation, and the infant was admitted to the teaching service at this time.

Following the infant's admission to the ward, she experienced a rapid deterioration in clinical presentation, becoming acidotic, cyanotic (dusky in color), less responsive, and lower in body temperature.

She was then transferred to the ICU, where she was intubated and an upper GI series was performed, which revealed a twisting (volvulus) of the intestine, for which emergent surgery was performed.

At surgery, the infant was found to have extensive necrosis (death) of the bowel. Attempts to mitigate this with antibiotic proved futile. A second surgery confirmed extensive bowel necrosis. Rather than removal of all the infant's intestines and a lifetime on parenteral nutrition, the infant was allowed to expire on March 4, 2000.

2. **Proposed Standard(s) of Care:** The standard of care for a vomiting infant is to obtain an appropriate history, perform an exam with special attention to the abdomen and for signs of dehydration or sepsis, obtain a complete blood count and blood chemistries, evaluate the urine, and obtain imaging studies warranted by the exam and labs. One should then begin rehydration either orally or intravenously.

3. **Deviation:** There was no deviation from the standard of care by Dr. . All the parameters set forth above were met. Additionally, he was prompt in his admission of the infant and his decision making was sound. There was no delay in care.

4. **Actual Harm Identified:** There was no actual harm to this unfortunate infant from Dr. emergency care. His evaluation was timely and appropriate. Had the child presented to the emergency department even one hour later, then the presenting

parameters would have been significantly more worrisome, in all likelihood prompting a more aggressive surgical/intensivist referral from the emergency evaluator.

5. **Potential Harm Identified:** Two minor criticisms of the emergency evaluation are warranted. First, in an infant of this age, with a history of prematurity, it is very likely sepsis may be present. Therefore, obtaining blood cultures when having initial blood drawn would be efficatious. Also, along these lines, obtaining a urine would be indicated. Neither blood cultures, nor a urinalysis were obtained in the emergency dept. Both of these were obtained upon admission and were not clinically significant in the eventual outcome. However, blood cultures and urinalysis should be obtained in the initial evaluation of an infant where sepsis is highly possible.

6. **Aggravating Factor(s):** None identified.

7. **Mitigating Factor(s):** The emergency presentation, labs and imaging all pointed to an infant that did not require emergent surgical intervention.

8. **Consultant's Summary:** This evaluator feels that Dr. met the standard of care for a vomiting infant by appropriately assessing the infant's physical presentation, level of hydration, appropriately obtaining and interpreting labs and x-rays, and initiating rehydration therapy. Further, he met the standard by promptly discussing the case with the infant's attending and subsequently admitting the patient for further evaluation and therapy. There was no delay in care by Dr. The criticism that he did not act promptly on "bilious vomiting" is unrealistic. He did not witness the infant vomiting, and histories describing vomitous are often spurious and unreliable. His actions were appropriate.

9. **Records Reviewed:**

March 2, 2000	- Emergency Dept. Record's
March 2, 2000	- Admission History and Physical
March 2, 2000	- Intensivist Records
March 2, 2000	- Surgical consultation and operative report
March 2 – 4, 2000	- Hospital records, progress reports, nurses notes, lab data
March 4, 2000	- Operative report
March 4, 2000	- Discharge summary and death note

10. **Additional Documents and Information Necessary:** None

11. **Investigational Questions for Physician:** None

Case No. MD
Date: February 7, 2006